

Office of Statewide Health Planning and Development
2000 Quarterly Data File Labels

Data Item			2000	
Item No.	Col. Ref.		Column Label	Line Number Source
		Quarterly Report Information		
1	A	OSHPD Facility No.	FAC_NO	
2	B	Facility DBA Name	FAC_NAME	
3	C	Report Period Year_Quarter	YEAR_QTR	
4	D	Report Period Begin Date	BEG_DATE	
5	E	Report Period End Date	END_DATE	
6	F	Current Operating Status	OP_STATUS	
		General Hospital Information		
7	G	County Number	COUNTY	
8	H	Health Service Area	HSA	
9	I	Health Facility Planning Area	HFPA	
10	J	Type of Control	TYPE_CNTRL	
11	K	Type of Hospital	TYPE_HOSP	
12	L	Teaching or Small/Rural Hospital	TEACH_RURL	
13	M	Phone Number	PHONE	
14	N	Street Address	ADDRESS	
15	O	City	CITY	
16	P	Zip Code	ZIP_CODE	
17	Q	Chief Executive Officer	CEO	
		Utilization Data		
18	R	Licensed Beds	LIC_BEDS	25
19	S	Available Beds	AVL_BEDS	30
20	T	Staffed Beds	STF_BEDS	35
		Hospital Discharges		
21	U	Medicare - Traditional	DIS_MCAR	50
22	V	Medicare - Managed Care	DIS_MCAR_MC	55
23	W	Medi-Cal - Traditional	DIS_MCAL	60
24	X	Medi-Cal - Managed Care	DIS_MCAL_MC	65
25	Y	County Indigent Programs - Traditional	DIS_CNTY	70
26	Z	County Indigent Programs - Managed Care	DIS_CNTY_MC	75
27	AA	Other Third Parties - Traditional	DIS_THRD	80
28	AB	Other Third Parties - Managed Care	DIS_THRD_MC	85
29	AC	Other Indigent	DIS_INDGNT	90
30	AD	Other Payers (new)	DIS_OTH	95
31	AE	Total Hospital Discharges	DIS_TOT	100
32	AF	Long-term Care (LTC) Discharges	DIS_LTC	105

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Data Item			2000	
Item No.	Col. Ref.		Column Label	Line Number Source
		Patient (Census) Days		
33	AG	Medicare - Traditional	DAY_MCAR	150
34	AH	Medicare - Managed Care	DAY_MCAR_MC	155
35	AI	Medi-Cal - Traditional	DAY_MCAL	160
36	AJ	Medi-Cal - Managed Care	DAY_MCAL_MC	165
37	AK	County Indigent Programs - Traditional	DAY_CNTY	170
38	AL	County Indigent Programs - Managed Care	DAY_CNTY_MC	175
39	AM	Other Third Parties - Traditional	DAY_THRD	180
40	AN	Other Third Parties - Managed Care	DAY_THRD_MC	185
41	AO	Other Indigent	DAY_INDGNT	190
42	AP	Other Payers (new)	DAY_OTH	195
43	AQ	Total Patient (Census) Days	DAY_TOT	200
44	AR	Long-term Care (LTC) Patient (Census) Days	DAY_LTC	205
		Outpatient Visits		
45	AS	Medicare - Traditional	VIS_MCAR	250
46	AT	Medicare - Managed Care	VIS_MCAR_MC	255
47	AU	Medi-Cal - Traditional	VIS_MCAL	260
48	AV	Medi-Cal - Managed Care	VIS_MCAL_MC	265
49	AW	County Indigent Programs - Traditional	VIS_CNTY	270
50	AX	County Indigent Programs - Managed Care	VIS_CNTY_MC	275
51	AY	Other Third Parties - Traditional	VIS_THRD	280
52	AZ	Other Third Parties - Managed Care	VIS_THRD_MC	285
53	BA	Other Indigent	VIS_INDGNT	290
54	BB	Other Payers (new)	VIS_OTH	295
55	BC	Total Outpatient Visits	VIS_TOT	300
		Gross Inpatient Revenue		
56	BD	Medicare - Traditional	GRIP_MCAR	350
57	BE	Medicare - Managed Care	GRIP_MCAR_MC	355
58	BF	Medi-Cal - Traditional	GRIP_MCAL	360
59	BG	Medi-Cal - Managed Care	GRIP_MCAL_MC	365
60	BH	County Indigent Programs - Traditional	GRIP_CNTY	370
61	BI	County Indigent Programs - Managed Care	GRIP_CNTY_MC	375
62	BJ	Other Third Parties - Traditional	GRIP_THRD	380
63	BK	Other Third Parties - Managed Care	GRIP_THRD_MC	385
64	BL	Other Indigent	GRIP_INDGNT	390
65	BM	Other Payers (new)	GRIP_OTH	395
66	BN	Total Gross Inpatient Revenue	GRIP_TOT	400

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Item No.	Col. Ref.		Column Label	Line Number Source
		Gross Outpatient Revenue		
67	BO	Medicare - Traditional	GROP_MCAR	450
68	BP	Medicare - Managed Care	GROP_MCAR_MC	455
69	BQ	Medi-Cal - Traditional	GROP_MCAL	460
70	BR	Medi-Cal - Managed Care	GROP_MCAL_MC	465
71	BS	County Indigent Programs - Traditional	GROP_CNTY	470
72	BT	County Indigent Programs - Managed Care	GROP_CNTY_MC	475
73	BU	Other Third Parties - Traditional	GROP_THRD	480
74	BV	Other Third Parties - Managed Care	GROP_THRD_MC	485
75	BW	Other Indigent	GROP_INDGNT	490
76	BX	Other Payers (new)	GROP_OTH	495
77	BY	Total Gross Outpatient Revenue	GROP_TOT	500
		Deductions from Revenue		
78	BZ	Provision for Bad Debts	BAD_DEBT	545
79	CA	Medicare - Traditional Contractual Adjustments	CADJ_MCAR	550
80	CB	Medicare - Managed Care Contractual Adjustments	CADJ_MCAR_MC	555
81	CC	Medi-Cal - Traditional Contractual Adjustments	CADJ_MCAL	560
82	CD	Medi-Cal - Managed Care Contractual Adjustments	CADJ_MCAL_MC	565
83	CE	Dispro Share Payments for Medi-Cal Patient Days (SB 855)	DISP_855	566
84	CF	County Indigent Programs - Traditional Contractual Adj	CADJ_CNTY	570
85	CG	County Indigent Programs - Managed Care Contractual Adj	CADJ_CNTY_MC	575
86	CH	Other Third Parties - Traditional Contractual Adjustments	CADJ_THRD	580
87	CI	Other Third Parties - Managed Care Contractual Adj	CADJ_THRD_MC	585
88	CJ	Charity - Hill-Burton	CHAR_HB	590
89	CK	Charity - Other	CHAR_OTH	595
90	CL	Restricted Donations and Subsidies for Indigent Care	SUB_INDGNT	600
91	CM	Teaching Allowance	TCH_ALLOW	605
92	CN	Clinical Teaching Support	TCH_SUPP	610
93	CO	Other Adjustments and Allowances	DED_OTH	615
94	CP	Total Deductions from Revenue (new)	DED_TOT	620
		Capitation Premium Revenue		
95	CQ	Capitation Premium Revenue - Medicare	CAP_MCAR	650
96	CR	Capitation Premium Revenue - Medi-Cal	CAP_MCAL	660
97	CS	Capitation Premium Revenue - County Indigent Programs	CAP_CNTY	670
98	CT	Capitation Premium Revenue - Other Third Parties	CAP_THRD	680
99	CU	Total Capitation Premium Revenue	CAP_TOT	700

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Data Item			2000	
Item No.	Col. Ref.		Column Label	Line Number Source
		Net Patient Revenue		
100	CV	Medicare - Traditional	NET_MCAR	750
101	CW	Medicare - Managed Care	NET_MCAR_MC	755
102	CX	Medi-Cal - Traditional	NET_MCAL	760
103	CY	Medi-Cal - Managed Care	NET_MCAL_MC	765
104	CZ	County Indigent Programs - Traditional	NET_CNTY	770
105	DA	County Indigent Programs - Managed Care	NET_CNTY_MC	775
106	DB	Other Third Parties - Traditional	NET_THRD	780
107	DC	Other Third Parties - Managed Care	NET_THRD_MC	785
108	DD	Other Indigent	NET_INDGNT	790
109	DE	Other Payers (new)	NET_OTH	795
110	DF	Total Net Patient Revenue	NET_TOT	800
		Other Revenue and Expense Data		
111	DG	Other Operating Revenue	OTH_OP_REV	810
112	DH	Total Operating Expenses	TOT_OP_EXP	830
113	DI	Physician Professional Component Expenses (PPC)	PHY_COMP	835
114	DJ	Nonoperating Revenue Net of Nonoperating Expenses	NONOP_REV	845
		Purchased Inpatient Services		
115	DK	Discharges	DIS_PIPS	850
116	DL	Patient Days	DAY_PIPS	855
117	DM	Expenses	EXP_PIPS	860
		Purchased Outpatient Services		
118	DN	Expenses	EXP_POPS	870
		Other Financial Data Items		
119	DO	Total Capital Expenditures	CAP_EXP	880
120	DP	Fixed Assets Net of Accumulated Depreciation	FIX_ASSETS	885
121	DQ	Dispro. Share Funds Transferred to Related Public Entity	DISP_TRNFR	900

CALCULATIONS AND FORMULAS USING 2000 OSHPD QUARTERLY REPORTS

Utilization Calculations

Average Length of Stay (ALOS)

Average Length of Stay (excluding LTC)

Licensed Bed Occupancy Rate

Available Bed Occupancy Rate

Staffed Bed Occupancy Rate

Occupied Beds (Average Daily Census)

Adjusted Patient Days

Formulas

Patient Days Total (Line No. 200) ÷ Discharges Total (Line No. 100)

Note: To calculate ALOS by payer category, see table below.

[Patient Days Total (Line No. 200) - Patient Days Long-term Care (Line No. 205)] ÷ [Discharges Total (Line No. 100) - Discharges Long-term Care (Line No. 105)]

Patient Days Total (Line No. 200) ÷ (Licensed Beds (Line No. 25) x Days in Report Period)

Days in Report Period is Report Period End Date (END_DATE) minus Report Period Begin Date (BEG_DATE) plus one.

Patient Days Total (Line No. 200) ÷ (Available Beds (Line No. 30) x Days in Report Period)

Patient Days Total (Line No. 200) ÷ (Staffed Beds (Line No. 35) x Days in Report Period)

Licensed Beds (Line No. 25) x "Licensed Bed Occupancy Rate"

[(Gross Inpatient Revenue Total (Line No. 400) + Gross Outpatient Revenue Total (Line No. 500)) ÷ Gross Inpatient Revenue Total (Line No. 400)] x Patient Days Total (Line No. 200)

Calculations by Payer Category

	ALOS	Gross I/P Rev Per Day	Gross I/P Rev per Discharge	Gross O/P Rev Per Visit
Medicare – Traditional	L150 ÷ L50	L350 ÷ L150	L350 ÷ L50	L450 ÷ L250
Medicare – Managed Care	L155 ÷ L55	L355 ÷ L155	L355 ÷ L55	L455 ÷ L255
Medi-Cal – Traditional	L160 ÷ L60	L360 ÷ L160	L360 ÷ L60	L460 ÷ L260
Medi-Cal – Managed Care	L165 ÷ L65	L365 ÷ L165	L365 ÷ L65	L465 ÷ L265
Co. Indigent Prog. – Traditional	L170 ÷ L70	L370 ÷ L170	L370 ÷ L70	L470 ÷ L270
Co. Indigent Prog. – Managed Care	L175 ÷ L75	L375 ÷ L175	L375 ÷ L75	L475 ÷ L275
Other Third Parties - Traditional	L180 ÷ L80	L380 ÷ L180	L380 ÷ L80	L480 ÷ L280
Other Third Parties - Managed Care	L185 ÷ L85	L385 ÷ L185	L385 ÷ L85	L485 ÷ L285
Other Indigent	L190 ÷ L90	L390 ÷ L190	L390 ÷ L90	L490 ÷ L290
Other Payers	L195 ÷ L95	L395 ÷ L195	L395 ÷ L95	L495 ÷ L295

CALCULATIONS AND FORMULAS USING 2000 OSHPD QUARTERLY REPORTS

Financial Calculations

Formulas

Gross Inpatient Revenue Per Discharge

Gross Inpatient Revenue Total (Line No. 400) ÷
Discharges Total (Line No. 100)

Gross Inpatient Revenue Per Day

Gross Inpatient Revenue Total (Line No. 400) ÷
Patient Days Total (Line No. 200)

Gross Outpatient Revenue Per Visit

Gross Outpatient Revenue Total (Line No. 500) ÷
Outpatient Visits Total (Line No. 300)

Note: To compute these amounts by payer category, use the formulas on the previous page.

Net Inpatient Revenue (est.)

[Gross Inpatient Revenue Total (Line No. 400) ÷
(Gross Inpatient Revenue Total (Line No. 400) +
Gross Outpatient Revenue Total (Line No. 500))] x
Net Patient Revenue Total (Line No. 800)

Net Inpatient Revenue by Payer (est.)

You can calculate Net Inpatient Revenue by payer category by substituting payer detail (Line Nos. 350-395, 450-495, and 750-795) for "Total".

Net Outpatient Revenue (est.)

[Gross Outpatient Revenue Total (Line No. 500) ÷
(Gross Inpatient Revenue Total (Line No. 400) +
Gross Outpatient Revenue Total (Line No. 500))] x
Net Patient Revenue Total (Line No. 800)

Net Outpatient Revenue by Payer (est.)

You can calculate Net Outpatient Revenue by payer category by substituting payer detail (Line Nos. 350-395, 450-495, and 750-795) for "Total".

Note: You can divide "Net Inpatient Revenue" by Patient Days and/or Discharges, and "Net Outpatient Revenue" by Outpatient Visits to calculate the average amount collected per day/discharge/visit. You can perform this calculation in "Total" or for each payer category.

Inpatient Operating Expenses (est.)

[Gross Inpatient Revenue Total (Line No. 400) ÷
(Gross Inpatient Revenue Total (Line No. 400) +
Gross Outpatient Revenue Total (Line No. 500))] x
Total Operating Expenses (Line No. 830)

Outpatient Operating Expenses (est.)

[Gross Outpatient Revenue Total (Line No. 500) ÷
(Gross Inpatient Revenue Total (Line No. 400) +
Gross Outpatient Revenue Total (Line No. 500))] x
Total Operating Expenses (Line No. 830)

Note: You can divide "Inpatient Operating Expenses" by Patient Days and/or Discharges, and "Outpatient Operating Expenses" by Outpatient Visits to estimate the average cost per day/discharge/visit.

CALCULATIONS AND FORMULAS USING 2000 OSHPD QUARTERLY REPORTS

Financial Calculations

Formulas

Pre-tax Net Income (Loss)

Net Patient Revenue Total (Line No. 800) + Other Operating Revenue (Line No. 810) - Total Operating Expenses (Line No. 830) + Net Nonoperating Revenue and Expenses (Line No. 840)

Operating Margin

("Net from Operations" ÷ "Total Operating Revenue") x 100

"Net from Operations" equals Net Patient Revenue Total (Line No. 800) + Other Operating Revenue (Line No. 810) - Total Operating Expenses (Line No. 830)

"Total Operating Revenue" equals Net Patient Revenue Total (Line No. 800) + Other Operating Revenue (Line No. 810)

Total Margin

("Pre-tax Net Income" ÷ "Total Operating Revenue") x 100

"Pre-tax Net Income" and "Total Operating Revenue" are defined above.

Cost-to-Charge Ratio

[Total Operating Expenses (Line No. 830) - Other Operating Revenue (Line No. 810)] ÷ [Gross Inpatient Revenue Total (Line No. 400) + Gross Outpatient Revenue Total (Line No. 500)]

Percent of Gross Revenue Collected

[Net Patient Revenue Total (Line No. 800) ÷ (Gross Inpatient Revenue Total (Line No. 400) + Gross Outpatient Revenue Total (Line No. 500))] x 100

Note on Disproportionate Share Payments and Transfers

Disproportionate Share Payments for Medi-Cal Patient Days (SB 855) (Line No. 566) includes the gross amount of SB 855 Disproportionate Share (DSH) payments received. Disproportionate Share Funds Transferred to a Related Public Entity (Line No. 900) is an optional reporting item that is applicable to county, district, and the University of California hospitals, and reflects DSH payments that a hospital transfers back to a related entity. As a result, you may want to adjust certain financial data, such as Total Deductions from Revenue (Line No. 620) and Net Patient Revenue (Line No. 800), to account for such transfers. Because reporting a DSH Transfer (Line No. 900) is optional, a "zero" could mean that no DSH transfers were made or that the hospital elected to leave the field blank.

CALCULATIONS AND FORMULAS USING 2000 OSHPD QUARTERLY REPORTS

Uncompensated Care

Uncompensated Care Costs for Tobacco Tax Formula

The following formulas are defined in law and are used by the Office to calculate each hospital's uncompensated care costs, and are applicable only to the allocation of Tobacco Tax funds provided by AB 75 and AB 99 (Statutes of 1989 and 1991). Other formulas and definitions may exist for determining uncompensated care costs in non-Tobacco Tax allocation situations.

For county hospitals, and for non-county hospitals located in a county without a county hospital	[Gross Inpatient Revenue County Indigent Programs – Traditional and Managed Care (Line No. 370 + 375) + Gross Outpatient Revenue County Indigent Programs – Traditional and Managed Care (Line No. 470 + 475) + Deductions Charity - Other (Line No. 595)] x “Cost-to-Charge Ratio”
For non-county hospitals located in a county with a county hospital	[Deductions County Indigent Programs – Traditional and Managed Care (Line No. 570 + 575) + Deductions Charity - Other (Line No. 595)] x “Cost-to-Charge Ratio”

“Cost-to-Charge Ratio” is defined above.

Uncompensated Care

When analyzing “Uncompensated Care”, you must first define it. As noted above, the State uses two definitions for its Tobacco Tax calculations. The most common definition for “Uncompensated Care” is the sum of Bad Debts (Line No. 545) and Charity – Other (Line No. 595). However, this definition does not reflect OSHPD’s unique database and reporting requirements. Below are some issues to consider:

- You should use the data associated with the County Indigent Programs (CIP) payer category. This payer category was established with the passage of California's Tobacco Tax legislation, and includes those indigent patients who are the responsibility of a county. Prior to this legislation, these indigent patients were classified as Other payers and uncollectible amounts were reported as Charity – Other. These write-offs now appear as CIP Contractual Adjustments.

Keep in mind that CIP Gross Patient Revenue (Line Nos. 370, 375, 470 and 475) measures the volume of services provided, while CIP Contractual Adjustments (Line Nos. 570 and 575) reflects the amount of uncollectible charges.

- If you want to include non-county indigent patients in your analysis, you need to include the Other Indigent payer category. This category relates to indigent patients who are NOT the responsibility of a county. The data for Other Indigent was formerly reported in Other Payers.
- Some data users may want to include Teaching Allowances (Line No. 605) in their analysis. This amount is reported only by the University of California hospitals, and reflects write-offs for services provided to indigent patients who benefit the hospital’s medical education programs.
- Lastly, if you want to use Charity - Other net of any related compensation, you should subtract Restricted Donations and Subsidies for Indigent Care (Line No. 600) from Charity - Other. As defined, Provision for Bad Debts (Line No. 545) is reported net of Bad Debt Recoveries.

Office of Statewide Health Planning and Development
Glossary for 2000 Quarterly Financial and Utilization Report Data File

Data Item	Definition
AVAILABLE BEDS	The average daily complement of beds (excluding nursery bassinets) physically existing and actually available for overnight use, regardless of staffing levels. Excludes beds placed in suspense or in nursing units converted to non-patient care uses which cannot be placed into service within 24 hours.
CAPITAL EXPENDITURES	The dollar value of all additions to property, plant and equipment, including amounts which have the effect of increasing the capacity, efficiency, life-span, or economy of the operation of an existing capital asset. Includes additions to construction-in-process.
CAPITATION PREMIUM REVENUE	The total amount of capitated revenue received (per member per month payments) for patients enrolled in managed care health plans. For 2000, Capitation Premium Revenue is reported separately from Deductions from Revenue, but still included in Net Patient Revenue.
CAPITATION PREMIUM REVENUE - COUNTY INDIGENT PROGRAMS	See Capitation Premium Revenue .
CAPITATION PREMIUM REVENUE - MEDICAL	See Capitation Premium Revenue .
CAPITATION PREMIUM REVENUE - MEDICARE	See Capitation Premium Revenue .
CAPITATION PREMIUM REVENUE - OTHER THIRD PARTIES	See Capitation Premium Revenue .
CHARITY - HILL-BURTON	Charity care provided by hospitals to satisfy obligations related to the federal Hill-Burton Program. On some OSHPD products, Charity - Hill-Burton is combined with Other Adjustments and Allowances .
CHARITY - OTHER	The difference between gross patient revenue (based on full established charges) for services rendered to patients who are unable to pay for all or part of the services provided, and the amount paid by or on behalf of the patient. Includes charity care provided by non-county hospitals to indigent patients who are not the responsibility of the county.
CHIEF EXECUTIVE OFFICER	The Chief Executive Officer (CEO) of the hospital, or the person in charge of day-to-day operations of the hospital.
CITY	The city in which the hospital is located.
CLINICAL TEACHING SUPPORT	Unique to the University of California Hospitals, Clinical Teaching Support funds cover the cost of treating certain cases that provide educational benefit as well as the exploration of current medical technology and techniques. Patients are typically unable to pay for all or part of these services. These funds are not considered compensation for bad debts. Also known as CTS funds.
CONTRACTUAL ADJUSTMENTS	The difference between billings at full established rates and amounts received or receivable from third-party payers under formal contract agreements. See Payer Category .
COUNTY INDIGENT PROGRAMS - MANAGED CARE	The County Indigent Programs - Managed Care category includes indigent patients covered under Welfare and Institutions Code Section 17000 and are covered by a managed care plan funded by a county. This category was previously reported in the Other Third Parties category.

Office of Statewide Health Planning and Development
Glossary for 2000 Quarterly Financial and Utilization Report Data File

Data Item	Definition
COUNTY INDIGENT PROGRAMS - TRADITIONAL	The County Indigent Programs - Traditional category includes indigent patients covered under Welfare and Institution Code Section 17000 and was previously reported in the County Indigent Programs category. Also included are patients paid for in whole or in part by the County Medical Services Program (CMSP), California Health Care for Indigent Program (CHIP or tobacco tax funds), and other funding sources whether or not a bill is rendered. This category also includes indigent patients who are provided care in county hospitals, or in certain non county hospitals where no county-operated hospital exists, whether or not a bill is rendered.
COUNTY NUMBER	The County in which the hospital is located. There are 58 counties in California. Please note that no hospitals are located in the County of Alpine.
DEDUCTIONS FROM REVENUE	The difference between gross patient revenue (charges based at full established rates) and amounts received from patients or third-party payers for services performed. Includes contractual adjustments, charity care, provisions for bad debts , and other adjustments and allowances which reduce gross patient revenue. Capitation premium revenue is reported separately from deductions from revenue. Each deduction from revenue category is defined separately in this glossary.
DISCHARGES	A discharge is the formal release of a formally admitted inpatient from the hospital, including deaths at the hospital. Also counted is the transfer (discharge) of an inpatient from one type of care (Acute Care, Psychiatric Care, Chemical Dependency Care, Rehabilitation Care, Long-Term Care, and Residential Care) to another type of care within the hospital. Excludes nursery discharges; service discharges, which are transfers within a type of care; and purchased inpatient discharges. See Payer Category .
DISPROPORTIONATE SHARE FUNDS TRANSFERRED TO RELATED PUBLIC ENTITY	The amount of Medi-Cal disproportionate share payments provided by SB 855 and/or SB 1255, SB 1732, and/or Graduate Medical Education that were transferred from the hospital to a related public entity. Only county, district, and University of California hospitals will report this item. This is an optional data field on the Quarterly Report..
DISPROPORTIONATE SHARE PAYMENTS FOR MEDI-CAL PATIENT DAYS (SB 855)	Supplemental payments received by hospitals serving a high percentage of Medi-Cal and other low income patients. Authorized under Senate Bill 855 (Chapter 279,1991) these payments are funded from intergovernmental transfers from public agencies (counties, hospital districts, and the University of California system) to the State and from federal matching funds.
FACILITY DBA NAME	The facility Doing Business As (DBA) name
FIXED ASSETS (Net of Accumulated Depreciation)	Net fixed assets are the historical cost of land, plus the cost of land improvements, building and improvements, leasehold improvements, equipment, and construction-in-progress, less accumulated depreciation and amortization.
GROSS INPATIENT REVENUE	Total inpatient charges at the hospital's full established rates for daily hospital services, inpatient ambulatory services, and inpatient ancillary services before deductions from revenue are applied. See Payer Category .
GROSS OUTPATIENT REVENUE	Total outpatient charges at the hospital's full established rates for outpatient ambulatory and outpatient ancillary services rendered and goods sold. See Payer Category .
HEALTH FACILITY PLANNING AREA (HFPA)	A numeric code denoting the Health Facility Planing Area (HFPA) in which the hospital is located. The HFPA is a geographic subdivision of a Health Service Area (HSA) and is defined by OSHPD for evaluating existing and required hospitals and services.

Office of Statewide Health Planning and Development
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Data Item	Definition
HEALTH SERVICE AREA (HSA)	A numeric code denoting the HSA in which the hospital is located. The HSA's geographic area, consisting of one or more contiguous counties, is designated by the Federal Department of Health and Human Services for health planning on a regional basis. There are 14 HSAs in California.
HOSPITAL DISCHARGES	See Discharges .
LICENSED BEDS	The number of licensed beds (excluding beds placed in suspense and nursery bassinets) stated on the hospital license at the end of the reporting period.
LONG-TERM CARE (LTC) DISCHARGES	The formal release of a formally admitted LTC patient from the hospital, including deaths at the hospital. Also counted is the transfer (discharge) of a LTC patient to another type of care. (See Discharges for more information.) On the Quarterly Report, this is an optional data field.
LONG-TERM CARE (LTC) PATIENT DAYS	Hospitals which provide skilled nursing care, intermediate care, sub acute care, and other long-term care services are encouraged to report this item. Also included are patient days of skilled nursing care provided in swing beds. This is an optional data field on the Quarterly Report.
MANAGED CARE	Managed care patients are patients enrolled in a managed care plan to receive health care from providers on a pre-negotiated or per diem basis, usually involving utilization review (includes Health Maintenance Organizations (HMO), Health Maintenance Organizations with Point-of-Service option (POS) Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), Exclusive Provider Organizations with Point-of-Service option, etc.).
MEDI-CAL - MANAGED CARE	The Medi-Cal Managed Care category includes patients covered by a managed care plan funded by Medi-Cal and was previously reported in the Other Third Parties category. See Managed Care .
MEDI-CAL - TRADITIONAL	The Medi-Cal-Traditional category includes patients who are qualified as needy under state laws and was previously reported in the Medi-Cal category.
MEDICARE - MANAGED CARE	The Medicare - Managed Care category includes patients who are qualified as needy under state laws and was previously reported in the Medi-Cal category. See Managed Care .
MEDICARE - TRADITIONAL	The Medicare - Traditional category includes patients covered under the Social Security Amendments of 1965 and was previously reported in the Medicare category. These patients are primarily the aged and needy.
NET PATIENT REVENUE	Gross patient revenue less deductions from revenue. This amount is more comparable than gross patient revenue because it indicates the actual amount received from patients and third party payers. Includes disproportionate share payments (before any transfers to related entities) and capitation premium revenue. See Payer Category .
NON-OPERATING REVENUE NET OF NON-OPERATING EXPENSES	If non-operating expenses are greater than non-operating revenue, the amount is entered as a negative number (with brackets). Non operating items are those revenue and expenses that do not related directly tot he provision of health care services.
OPERATING STATUS (CURRENT)	Indicates whether a hospital is open or closed at the end of the quarter.
OSHPD FACILITY NO.	A nine-digit hospital identification number assigned by OSHPD for reporting purposes. OSHPD facility numbers are typically based on a facility's operating license.

Office of Statewide Health Planning and Development
Glossary for 2000 Quarterly Financial and Utilization Report Data File

Data Item	Definition
OTHER ADJUSTMENTS AND ALLOWANCES	Includes policy discounts, administrative adjustments, and other deductions from revenue that are not included elsewhere.
OTHER INDIGENT	The Other Indigent category includes indigent patients, excluding those who are recorded in the Count Indigent Programs category and including those who are being provided charity care by the hospital. This category was previously reported the Other Payers category.
OTHER OPERATING REVENUE	Revenue generated by health care operations from non-patient care services to patients and others. Examples include non-patient food sales, refunds and rebates, supplies sold to non-patients, and Medical Records abstract sales. Does not include interest income.
OTHER PAYERS	The Other Payers category includes all patients who do not belong in the categories listed above, such as those designated as self-pay and U.C. teaching hospital patients who are provided care with Support for Clinical Teaching funds.
OTHER THIRD PARTIES- MANAGED CARE	The Other Third Parties - Managed Care category includes patients covered by managed care plans other than those funded by Medicare, Medi-Cal, or a county; and was previously reported in the Other Third Parties category. See Managed Care .
OTHER THIRD PARTIES-TRADITIONAL	The Other Third Parties - Traditional category includes all other forms of health coverage excluding managed care plans. Examples include Short-Doyle, CHAMPUS, IRCA/SLIAG, California Children's Services, Health Family, indemnity plans, fee-for-service plans, and Workers' Compensation. This category was previously reported in the Other Third Parties category.
OUTPATIENT VISITS	A visit is an appearance of an outpatient in the hospital for ambulatory services or the appearance of a private referred outpatient in the hospital for ancillary services. In both instances, the patient is typically treated and released the same day, and is not formally admitted as an inpatient, even though occasional overnight stays may occur. Included are outpatient emergency room visits, outpatient clinic visits, referred ancillary service visits, home health contact, and day care days, where the outpatient is treated and released the same day. Also included are outpatient chemical dependency visits, hospice outpatient visits, and adult day health care visits. See Payer Category .
PATIENT (CENSUS) DAYS	The number of census days that all formally admitted inpatients spent in the hospital during the reporting period. Patient days include the day of admission, but not the day of discharge. If both admission and discharge occur on the same day, one patient day is counted. Nursery days and purchased inpatient days are excluded. See Payer Category .
PAYER CATEGORY	Annual and Quarterly Reports include financial and utilization data by payer category, which is defined as the third-party or individual who is responsible for the predominant portion of a patient's bill. For 2000 Annual and Quarterly Reports, the Office has established 10 payer categories: Medicare - Traditional, Medicare - Managed Care, Medi-Cal - Traditional, Medi-Cal - Managed Care, County Indigent Programs - Traditional, County Indigent Programs - Managed Care, Other Third Parties - Traditional, Other Third Parties - Managed Care, Other Indigent, and Other Payers. Definitions of these payer categories are included in this glossary.
PHONE NUMBER	The main business phone number of the hospital.

Office of Statewide Health Planning and Development
Glossary for 2000 Quarterly Financial and Utilization Report Data File

Data Item	Definition
PHYSICIAN PROFESSIONAL COMPONENT (PPC) EXPENSES	Expense included in the physicians' total compensation. This includes all amounts paid or to be paid to hospital-based physicians and residents for patient care and recorded as an expense of the hospital for the reporting period. PPC expenses are an optional reporting item on Quarterly Reports.
PROVISION FOR BAD DEBTS	Accounts receivable which are determined to be uncollectible due to the patient's unwillingness to pay and are charged as a credit loss against gross patient revenue. Bad debts are classified as deductions from revenue, and not included in operating expenses.
PURCHASED INPATIENT SERVICES	Inpatient services purchased under contract from another hospital on an arranged basis for patients who are not formally admitted as inpatients of the purchasing hospital. This situation may arise due to managed care contract requirements of the lack of appropriate hospital technology at the purchasing hospital. The reporting of these data is optional on the Quarterly Report.
PURCHASED INPATIENT SERVICES - DISCHARGES	Number of discharges related to inpatient care services purchased from and provided by another hospital. This situation may arise when the hospital is unable to provide services on-site and may be contractually obligated to seek such services elsewhere. Purchased inpatient discharges are excluded from Discharges . This is an optional reporting item on the Quarterly Report.
PURCHASED INPATIENT SERVICES - EXPENSES	Expenses incurred by the purchasing hospital when inpatient services, including ancillary services, are provided by another hospital for patients who are the responsibility of the purchasing hospital. The reporting of this data element is optional on the Quarterly Report.
PURCHASED INPATIENT SERVICES - PATIENT DAYS	Number of inpatient days of care (census days) for patients whose inpatient care was purchased from and provided by another hospital. This situation may arise when the hospital is unable to provide services on-site and may be contractually obligated to seek such services elsewhere. Purchased inpatient days are not included in Patient Days, and are optional on the Quarterly Report..
PURCHASED OUTPATIENT SERVICES - EXPENSES	Expenses incurred by the purchasing hospital when outpatient services, including ancillary services, are provided by another hospital for patients who are the responsibility of the purchasing hospital. On the Quarterly Report, the reporting of this data element is optional .
REPORT PERIOD BEGIN DATE	The first day of the reporting period.
REPORT PERIOD END DATE	The last day of the reporting period.
REPORT PERIOD YEAR_ QUARTER	The four digit calendar yearend quarter which denotes the report period.
RESTRICTED DONATIONS & SUBSIDIES FOR INDIGENT CARE	Donations, grants, or subsidies voluntarily provided for the care of medically indigent patients. Includes discretionary and/or formula tobacco tax funds provided by a county to a non-county hospital.
STAFFED BEDS	The average daily complement of beds (excluding nursery bassinets) that are set-up, staffed, and equipped, and in all respects, ready for use by patients remaining in the hospital overnight.
STREET ADDRESS	The street address where the facility is located.
TEACHING ALLOWANCE	The amount of charges written-off when it is determined by the teaching hospital that the selected patient does not have the ability to pay but whose case would benefit the teaching mission of the hospital. This reporting item is used only by the University of California hospitals.
TEACHING OR SMALL/RURAL HOSPITAL	Indicates if the hospital is a teaching hospital or considered a small and rural hospital.

Office of Statewide Health Planning and Development
Glossary for 2000 Quarterly Financial and Utilization Report Data File

Data Item	Definition
TOTAL OPERATING EXPENSES	Total costs incurred by revenue-producing and non-revenue producing cost centers for providing patient care at the hospital. Excludes non-operating expenses, provisions for income taxes, and provisions for bad debts.
TYPE OF CONTROL	Denotes the type of ownership and/or legal organization of a hospital licensee. The following five types of control are reported; District -Includes District hospitals; County/City -Includes hospitals operated by a County, County/City or City; Investor -Includes hospitals operated by an Investor-Individual, Investor-Partnership, or Investor-Corporation; Non Profit -Includes hospitals operated by a Church, Non-Profit Corporation, or Non-Profit Other; State . Includes State hospitals.
TYPE OF HOSPITAL	Indicates if a hospital's report contains comparable data, or if the data are considered non-comparable due to reporting modifications granted by OSHPD or the hospital's unique operating characteristics. There are six types of hospitals: COMPARABLE -Includes hospitals whose data and operating characteristics are comparable with other hospitals, KAISER -Includes hospitals operated by Kaiser Hospital Foundation, Also includes the two regional Kaiser organization entities, which report consolidated financial data for all the hospitals in the regions., LTC Emphasis - Includes large hospitals which emphasize long-term care (LTC) services, PHF -Includes hospitals licensed as Psychiatric Healthy Facilities, which provide mental health services, SHRINERS -Includes hospitals operated by Shriners Hospitals for Crippled Children which do not charge for services provided. STATE -Includes State hospitals, which provide care to the mentally disordered and developmentally disabled.
ZIP CODE	The zip code in which the hospital is located.

HOSPITAL QUARTERLY FINANCIAL AND UTILIZATION REPORT (Cont'd)

Facility DBA Name:		2000 Quarter Ending:	OSHPD Facility No.:
Line No.	UTILIZATION DATA ITEMS (Cont'd)	2000 QUARTER	
	Outpatient Visits (including ER, Clinic, Referred, Home Health Visits, and Day Care Days)		
250.	Medicare - Traditional		
255.	Medicare - Managed Care		
260.	Medi-Cal - Traditional		
265.	Medi-Cal - Managed Care		
270.	County Indigent Programs - Traditional		
275.	County Indigent Programs - Managed Care		
280.	Other Third Parties - Traditional		
285.	Other Third Parties - Managed Care		
290.	Other Indigent		
295.	Other Payors		
300.	Total Outpatient Visits (sum of lines 250 thru 295)		
	FINANCIAL DATA ITEMS		
	Gross Inpatient Revenue (including PPC charges)		
350.	Medicare - Traditional	\$	
355.	Medicare - Managed Care		
360.	Medi-Cal - Traditional		
365.	Medi-Cal - Managed Care		
370.	County Indigent Programs - Traditional		
375.	County Indigent Programs - Managed Care		
380.	Other Third Parties - Traditional		
385.	Other Third Parties - Managed Care		
390.	Other Indigent		
395.	Other Payors		
400.	Total Gross Inpatient Revenue (sum of lines 350 thru 395)	\$	
	Gross Outpatient Revenue (including PPC charges)		
450.	Medicare - Traditional	\$	
455.	Medicare - Managed Care		
460.	Medi-Cal - Traditional		
465.	Medi-Cal - Managed Care		
470.	County Indigent Programs - Traditional		
475.	County Indigent Programs - Managed Care		
480.	Other Third Parties - Traditional		
485.	Other Third Parties - Managed Care		
490.	Other Indigent		
495.	Other Payors		
500.	Total Gross Outpatient Revenue (sum of lines 450 thru 495)	\$	
	Deductions from Revenue		
545.	Provision for Bad Debts (including bad debt recoveries)	\$	
550.	Medicare - Traditional Contractual Adjustments		
555.	Medicare - Managed Care Contractual Adjustments		
560.	Medi-Cal - Traditional Contractual Adjustments		
565.	Medi-Cal - Managed Care Contractual Adjustments		
566.	Disproportionate Share Payments for Medi-Cal Patient Days (SB 855)	()	
570.	County Indigent Programs - Traditional Contractual Adjustments		
575.	County Indigent Programs - Managed Care Contractual Adjustments		
580.	Other Third Parties - Traditional Contractual Adjustments		
585.	Other Third Parties - Managed Care Contractual Adjustments		
590.	Charity - Hill-Burton		
595.	Charity - Other		
600.	Restricted Donations and Subsidies for Indigent Care	()	
605.	Teaching Allowance (for U.C. teaching hospitals only)		
610.	Clinical Teaching Support (for U.C. teaching hospitals only)	()	
615.	Other Adjustments and Allowances		
620.	Total Deductions from Revenue (sum of lines 545 thru 615)	\$	

HOSPITAL QUARTERLY FINANCIAL AND UTILIZATION REPORT (Cont'd)

Facility DBA Name:		2000 Quarter Ending:	OSHDP Facility No.:
Line No.	FINANCIAL DATA ITEMS (Cont'd)		2000 QUARTER
	Capitation Premium Revenue		
650.	Capitation Premium Revenue - Medicare		\$
660.	Capitation Premium Revenue - Medi-Cal		
670.	Capitation Premium Revenue - County Indigent Programs		
680.	Capitation Premium Revenue - Other Third Parties		
700.	Total Capitation Premium Revenue (sum of lines 650 thru 680)		\$
	Net Patient Revenue (Gross Patient Revenue less Deductions from Revenue plus Capitation Revenue)		
750.	Medicare - Traditional		\$
755.	Medicare - Managed Care		
760.	Medi-Cal - Traditional		
765.	Medi-Cal - Managed Care		
770.	County Indigent Programs - Traditional		
775.	County Indigent Programs - Managed Care		
780.	Other Third Parties - Traditional		
785.	Other Third Parties - Managed Care		
790.	Other Indigent		
795.	Other Payors		
800.	Total Net Patient Revenue (sum of lines 750 thru 795) (Line 400 + line 500 - line 620 + line 700)		\$
810.	Other Operating Revenue		\$
830.	Total Operating Expenses (including PPC expenses reported in line 840)		\$
835.	Physician Professional Component Expenses (PPC)**		\$
840.	Nonoperating Revenue Net of Nonoperating Expenses		\$
	Purchased Inpatient Services		
850.	Discharges (Not included in lines 50 thru 100)**		
855.	Patient Days (Not included in lines 150 thru 200)**		
860.	Expenses (included in line 830)**		\$
	Purchased Outpatient Services		
870.	Expenses (included in line 830)**		\$
880.	Total Capital Expenditures (excluding disposal of assets)		\$
885.	Fixed Assets Net of Accumulated Depreciation (including construction-in-progress)		\$
900.	Disproportionate Share Funds Transferred to Related Public Entity**		\$

** The reporting of this item is optional.

QUESTIONS

Please contact us at the following address, phone number, or FAX number:

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CERTIFICATION

I, _____, certify under penalty of perjury that to the best of my knowledge and information, the information reported is true and correct.

By: _____

Title: _____ Date: _____

OSHDP 2000-3 (Rev. 10/98)

Note: Effective with calendar quarters ended on or after March 31, 2000, all hospitals are required to prepare this quarterly report using the Office's Internet Hospital Quarterly Reporting System (IHQRS) and to submit the report to the Office's Internet web-site, unless the Office has granted approval in writing to submit this report using this standard report form.